

Nutritional Surveillance Project

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Nutrition and Health Surveillance in Khulna Division

Key results for the period: February 2001 to January 2002

Rural Bangladesh achieved a steady decline in malnutrition during the last decade but there are still millions of malnourished children and mothers leading impoverished lives. Since its inception in 1990 the HKI/IPHN Nutritional Surveillance Project (NSP) has been a source of high quality data on nutrition, health, socio-demography, food security and poverty in rural areas of all six divisions in the country. This bulletin presents NSP data collected in 2001 from rural areas in Khulna Division. The prevalence of malnutrition and anemia in children and mothers was lower than most other divisions in the country, but was still unacceptably high. According to international criteria, malnutrition in children and mothers was 'very high', 'serious' and even 'critical' at different times of the year, while anemia was a 'moderate' problem in both children (35%) and mothers (20%). Investing in nutrition is crucial because malnutrition contributes to poverty and impedes both social and economic development.

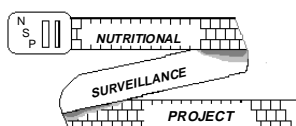
The prevalence of malnutrition in Bangladesh is amongst the highest in the world. Although there is an increasing magnitude of problems among the urban poor, 77% of the population still resides in rural areas, where most lack adequate access to food, health care and other basic needs. The Government of Bangladesh, donors and development agencies recognise that malnutrition is a major barrier to poverty alleviation and development in Bangladesh and warrants effective action. In order to design, monitor and evaluate policies and programs, detailed information on the magnitude and determinants of the problem is needed.

Information generated by the NSP over the past 12 years has helped inform policymakers, program managers and donor organizations on many development concerns in Bangladesh including health, nutrition, food security, gender disparities, and poverty. HKI encourages the use of its surveillance data to facilitate policy and program action for the benefit of the population from whom they were collected.

Following the successful experience of the HKI Nutrition and Health Surveillance System (NSS) in data sharing in Indonesia, the data collected by the NSP in Bangladesh in 2001 on key indicators of nutrition, health and their determinants are included in a CDROM that accompanies this series of bulletins.

Data collection in Khulna Division

Data are collected every 2 mo in rural areas of four sub-districts (*upazila*) in Khulna Division: Fakirhat, Kaligoni, Gangi, and Debhata. These four sub-districts were randomly selected when the new sampling design was introduced in February 1998, and provide data that are statistically representative of the division. A new sample of 1,500 households is randomly selected from the total of four sub-districts during each round of data collection as follows. Fifteen *mauza* (administrative unit within a sub-district) are randomly selected from each sub-district. One village is randomly selected from each *mauza*, and 25 households with at least one child aged <5 years are systematically sampled from each village. A precoded questionnaire is used to record data from each household on the health and nutrition of one



mother and all her children aged <5 years; household demography and socio-economic status; household food consumption; household food production; natural disasters, household crises and coping strategies; and participation in NGO programs.

Data are also collected from the five other divisions of the country: Barisal, Chittagong, Dhaka, Rajshahi and Sylhet. The data from all six rounds of data collection in the six divisions are aggregated to provide a nationally representative sample of 54,000 rural households each year.

Findings presented

In this bulletin, data are presented on a selection of indicators of household demographic and socio-economic status, household food security (loans for food and homestead gardening), caring practices (breastfeeding), the performance of national health programs (vitamin A capsule distribution), food consumption (household energy intake and consumption of non-cereal foods), health status (child and maternal diarrhea) and nutritional status (child and maternal nightblindness, anemia and anthropometry). The definition and method of data collection of each indicator are described together with the general findings for rural Bangladesh and the specific findings for Khulna Division. The figures show the data collected in Khulna Division. While the scope of this bulletin is limited to presenting the findings, they serve to facilitate discussion on the immediate and underlying causes of malnutrition and on ways to address it.

Demographic and socio-economic status (SEE TABLE)

What is indicated. The demographic and socio-economic status of a household determines the extent to which the household unit can adequately feed and care for all members, provide a healthy environment and gain access to health services. These factors are therefore important determinants of the health and nutritional status of household members.

Data collection method. A series of questions is asked to obtain the information shown in the Table.

Findings. *Rural Bangladesh* - Demographic and socio-economic conditions varied considerably between the six divisions. *Khulna Division* - The level of household crowding was higher than all other divisions (with Sylhet Division), despite having the lowest number of household members (with Rajshahi Division). The percentage of households with a closed latrine (60%) was also higher than all other divisions.

Loan for food in the last month (SEE FIG 1)

What is indicated. A loan for food is a good indicator of household food insecurity in Bangladesh because it is a coping strategy used when a household is unable to produce or purchase sufficient food for consumption.

Data collection method. The respondent is asked whether the household took a loan to obtain food in the last month, either in cash or in kind.

Findings. *Rural Bangladesh* - Overall, 12% of households took a food loan in 2001, ranging from 9% in Jun/Jul to 14% in Feb/Mar and Oct/Nov. *Khulna Division* - The percentage was two to three times the national rural average throughout the year, and was higher than all other divisions except Barisal Division.

Homestead gardening (SEE FIG 2)

What is indicated. Homestead gardening in Bangladesh has been shown to lower the risk of vitamin A deficiency in preschool children and mothers. Households that practice improved gardening techniques consume non-cereal foods more frequently and have a more diverse diet than other households.

Data collection method. Three types of homestead gardens are distinguished: 'traditional' homestead gardens which produce only gourd and traditional types of vegetables seasonally in scattered plots; 'improved' homestead gardens which produce a wider range of vegetables seasonally in fixed plots; and 'developed' homestead gardens which grow a wide variety of vegetables all year in fixed plots.

Findings. *Rural Bangladesh* - In 2001, 76% of households cultivated traditional gardens, 8% improved gardens and 1% developed gardens. *Khulna Division* - The percentage of households with improved gardens was 5% higher than the national rural average.

Breastfeeding of children aged <60 mo (SEE FIG 3)

What is indicated. Infants and young children should be exclusively breastfed for the first 6 mo of life because of nutritional and health benefits. Breastfeeding should continue well into the second year of life, complemented with nutritious foods from 6 mo of age.

Data collection method. The mother is asked whether her child is currently breastfed.

Findings. *Rural Bangladesh* - Throughout rural Bangladesh almost all mothers breastfed their children well into the second year of life (97% of children aged 12-14 mo and 88% of children aged

21-23 mo), and many for much longer. *Khulna Division* - The findings suggest that children in this division were breastfed for slightly longer than average for rural Bangladesh: 94% of children aged 21-23 mo were still breastfed.

Vitamin A capsule receipt in children aged 12-59 mo (SEE FIG 4)

What is indicated. Preschool children in Bangladesh need vitamin A supplements because their diet does not supply enough vitamin A and so they are at high risk of illness, blindness and dying due to vitamin A deficiency. The Government of Bangladesh currently aims to give every child aged 12-59 mo a high-dose vitamin A capsule (VAC) containing 200,000 IU twice a year at six-monthly intervals during the National Immunization Days for polio. IVACG/WHO also recommend that children aged 6-11 mo be given 100,000 IU vitamin A twice a year. However, these children are currently not included in the national VAC distribution campaigns because the polio vaccine has a target age of 12-59 mo.

Data collection method. The NSP monitors the coverage of the VAC program during a round of NSP data collection that follows a VAC distribution. During the year 2001, the NSP collected data on coverage of the VAC program in Feb/Mar for the November 2000 VAC distribution and in Jun/Jul for the May 2001 VAC distribution. The mother is asked whether her child received a VAC during the most recent distribution.

Findings. *Rural Bangladesh* - Coverage of the VAC program among children aged 12-59 mo increased from around 50% in the early 1990s to almost 90% in the late 1990s. The coverage in November 2000 and May 2001 was 97% and 96% respectively, exceeding all previous years. *Khulna Division* - Coverage of the VAC program (97%) was similar to the national rural average.

Household energy intake (SEE FIG 5)

What is indicated. Household energy intake is used as an indicator of household poverty: households with an energy intake <1805 kcal/person/d are considered 'extreme' or 'hard-core' poor, and households with an energy intake of 1805-2122 kcal/person/d are considered 'moderate' or 'absolute' poor¹. Household energy intake is also used as an indicator of household food security. However, this indicator neither incorporates the social or environmental dimensions of poverty, nor does it give an indication of the quality of the household diet.

Data collection method. Since December 2001, the

Table Household demography and socio-economic status in 2001

	Khulna Division	Rural Bangladesh
No. household members (mean)	5.1	5.5
Household crowding (median no. household members per 100 sq ft)	2.5	2.2
Female decision-maker (%)	2	4
Functionally landless ^a (%)	65	68
Manual labor as main source of income (%)	25	22
Clean source of drinking water ^b (%)	99	98
Closed latrine (%)	60	39
Parent's education ^c		
Mother	57	49
Father	51	50

^a Own <50 decimals (2000 m²) cultivable land

^b Water obtained from hand pump, deep tube well or tap

^c At least one year of formal education

Fig 1. Percentage of households that took a loan for food in the last month in 2001

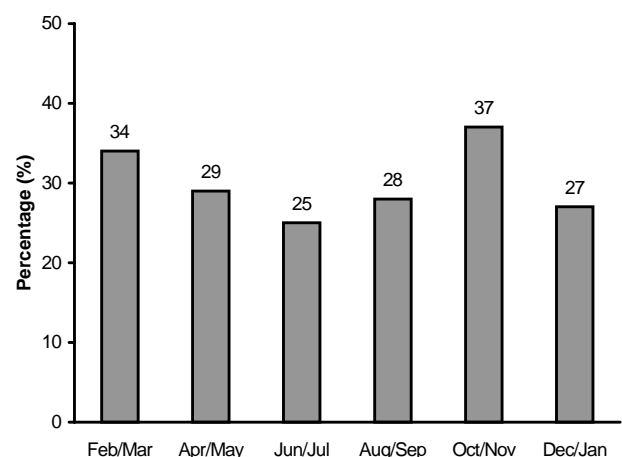


Fig 2. Percentage of households that participated in homestead gardening in 2001

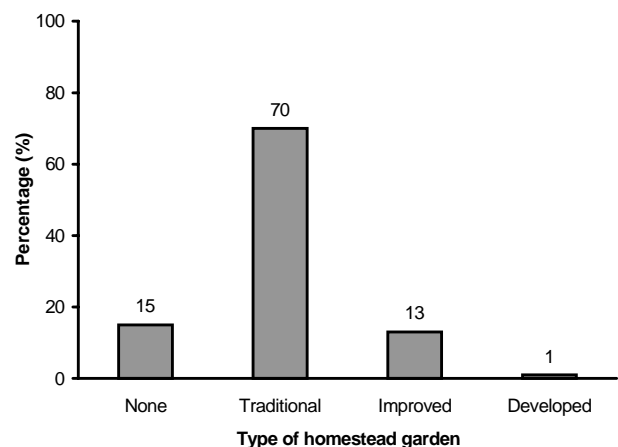
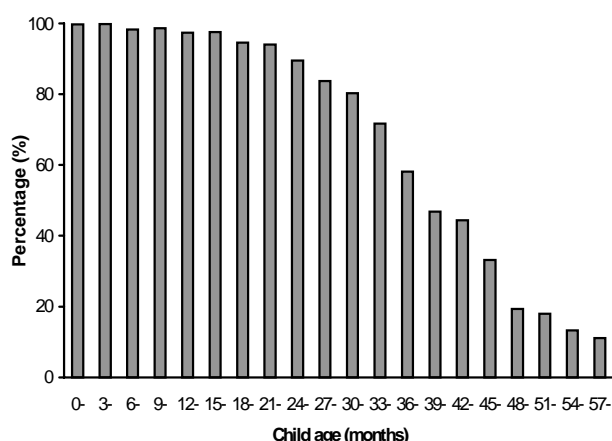
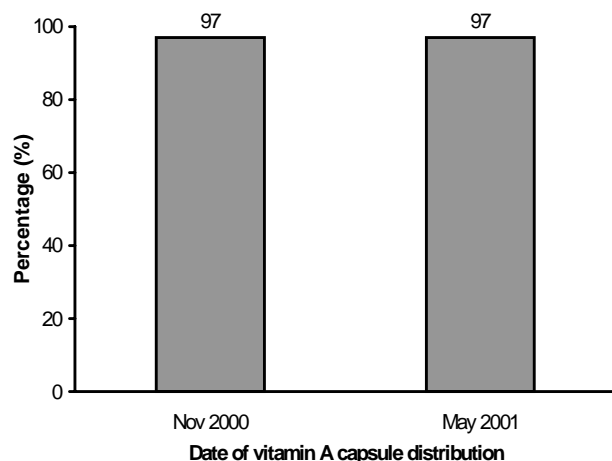
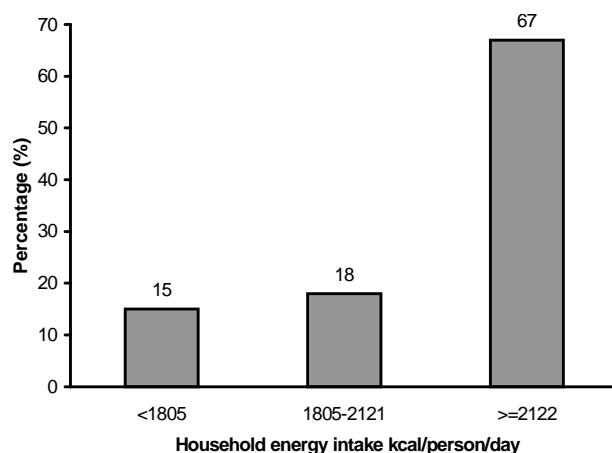


Fig 3. Percentage of breastfed children by age in 2001**Fig 4.** VAC coverage in children aged 12-59 mo in 2001**Fig 5.** Household energy intake in Dec 2001/Jan 2002

NSP has collected data on household energy intake using a 7-day list-recall method. The respondent is asked to list all food and beverage items consumed by household members in the previous week and to estimate the quantity of each item consumed. These data are converted to a value of daily energy intake per household member.

Findings. *Rural Bangladesh* - In Dec 2001/Jan 2002, 24% of rural households had an energy intake <1805 kcal/person/d and 23% had an energy intake of 1805-2122 kcal/person/d. *Khulna Division* - The percentage of households with a low energy intake (<2122 kcal/person/d) was lower than all other divisions (33%).

Household consumption of non-cereal foods (SEE FIG 6)

What is indicated. A high quality diet, which contains a diverse range of non-cereal foods that are good sources of micronutrients, reduces the risk of micronutrient deficiencies. One way to assess the quality and diversity of the household diet is to examine how often household members eat non-cereal foods.

Data collection method. The mother is asked to recall on how many days in the last 7 days the household members ate five common non-cereal foods: *dal* (lentils), eggs, green leafy vegetables, yellow/orange fruit or vegetables, and fish. A household is considered to have eaten a non-cereal food 'regularly' if household members ate it on ≥ 4 days in the last 7 days. As data on this indicator were not collected in Dec 2001/Jan 2002, data from the previous year are included in Fig 6 in order to show seasonal variation throughout the year.

Findings. *Rural Bangladesh* - During most of the year <10% of households ate *dal*, yellow/orange fruits or vegetables, eggs and green leafy vegetables regularly, and 40-70% households ate fish regularly. *Khulna Division* - Regular consumption of *dal* was about half the national rural average, while regular consumption of fish was on average about 9% lower.

Child and maternal diarrhea (SEE FIG 7)

What is indicated. Diarrhea is a form of morbidity that is relatively easy to monitor, because it occurs relatively frequently and respondents easily understand its definition. It is also a major cause of undernutrition in developing countries, particularly among young children. The prevalence of diarrhea reflects hygiene conditions both inside the house and in the neighborhood.

Data collection method. The mother is asked a series of questions to determine whether she and her child

had diarrhea in the last 24 hr. Diarrhea is defined as ≥ 3 loose, watery or mucoid stools in 24 hr.

Findings. *Rural Bangladesh* - The prevalence of diarrhea in mothers ranged from 0.6% in Aug/Sep to 1.3% in Apr/May. The prevalence was about five times higher among children aged 6-59 mo, ranging from 5.5% in Dec/Jan to 7.6% in Apr/May. *Khulna Division* - The prevalence of diarrhea in both mothers and children was lower than the national rural average. The prevalence peaked in Dec/Jan in mothers and Jun/Jul in children.

Child and maternal nightblindness (SEE FIG 8)

What is indicated. Vitamin A deficiency is associated with an increased risk of illness and dying and is a leading cause of blindness among children and mothers. Nightblindness is the first clinical sign of vitamin A deficiency and is considered a public health problem in areas where the prevalence in children aged 18-59 mo is $\geq 1\%$. For each person affected by nightblindness in a population, there are many more with a low vitamin A level, which increases the risk of illness and dying.

Data collection method. The mother is asked whether she or her child have difficulty seeing and therefore moving around when there is insufficient light, for example, at dusk. Fieldworkers verify that this is due to nightblindness and not to any other sight defect.

Findings. *Rural Bangladesh* - The prevalence of nightblindness in children fell from 3.6% in 1983 to 0.6% in 1997. The data collected in 2001 show that the prevalence (0.21%) has been sustained below the level that signals a public health problem. The prevalence in non-pregnant mothers was also low (0.40%). *Khulna Division* - The prevalence of nightblindness in both children and non-pregnant mothers was above the national rural average, albeit well below 1%.

Child and maternal anemia (SEE FIG 9)

What is indicated. The main cause of anemia in most of Bangladesh is iron deficiency. A mother who is iron deficient or anemic during her pregnancy has a greater risk of dying during childbirth and of giving birth to a small baby with low iron stores. Iron deficiency and anemia also impair the growth and learning ability of children, lower immunity to infectious diseases and reduce work capacity and productivity in adults. Anemia is considered a 'severe' public health problem if the prevalence is $\geq 40\%$ and a 'moderate' public health problem if the prevalence is 20-39%.

Fig 6. Percentage of households that consumed non-cereal foods regularly (≥ 4 d in previous week) in 2001. GLV = green leafy vegetables; YOFV = yellow/orange fruits or vegetables

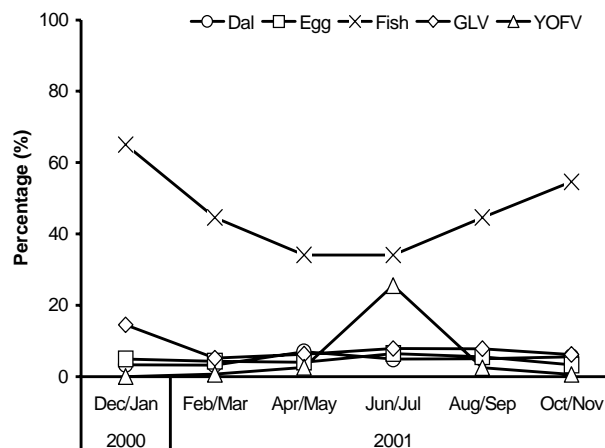


Fig 7. Percentage of children aged 6-59 mo and mothers with diarrhea in the previous 24 hr in 2001

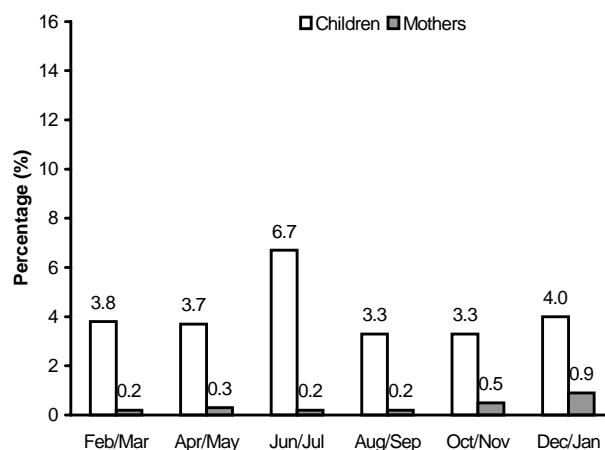


Fig 8. Percentage of children aged 18-59 mo and non-pregnant mothers with nightblindness in 2001

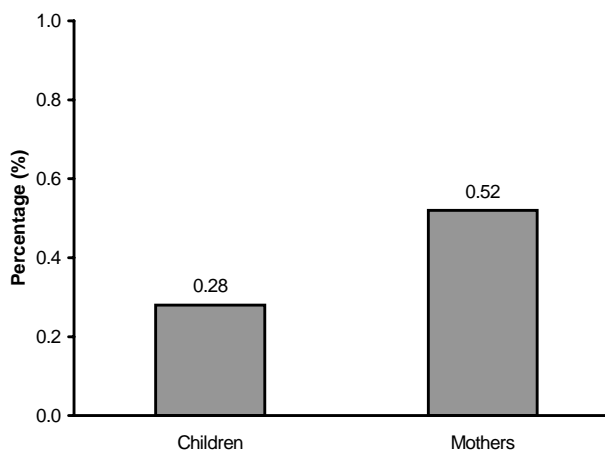


Fig 9. Percentage of children aged 6-59 mo and non-pregnant mothers with anemia in Oct/Nov 2001

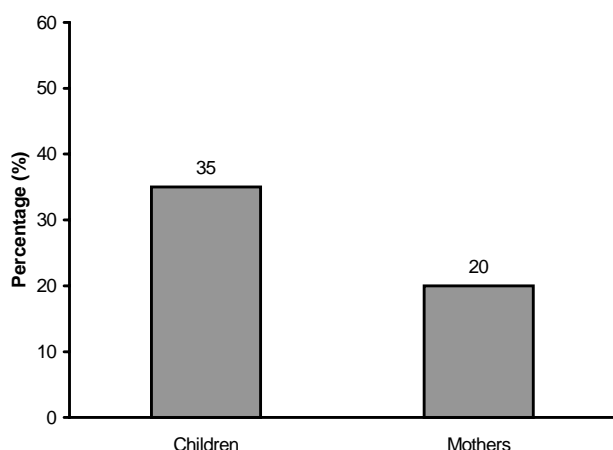


Fig 10. Percentage of wasted non-pregnant mothers (BMI < 18.5 kg/m²) in 2001

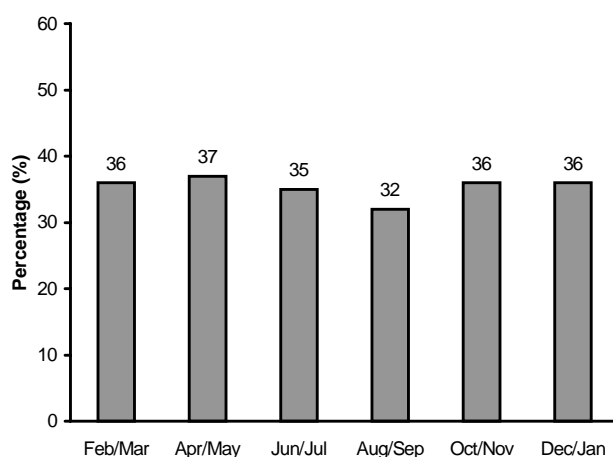
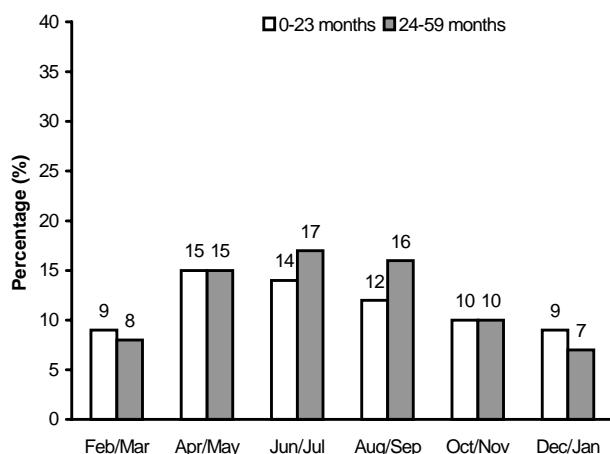


Fig 11. Percentage of wasted children aged 0-23 mo and 24-59 mo (WHZ < -2 SD) in 2001



Data collection method. A national anemia survey was conducted by the NSP during routine data collection in Oct/Nov 2001. A drop of capillary blood was taken from the finger of a random sample of 1,148 children and 1,093 mothers, and the hemoglobin concentration (Hb, g/dL) was estimated using a portable hemoglobinometer (HemoCue®). Anemia is defined as Hb < 11 g/dL for children aged 6-59 mo and Hb < 12 g/dL for non-pregnant women.

Findings. *Rural Bangladesh* - Almost one-half of children (47%) and one-third of mothers (33%) in rural Bangladesh were anemic in Oct/Nov 2001. *Khulna Division* - The prevalence of anemia in both children (35%) and mothers (20%) was lower than all other divisions.

Maternal wasting (SEE FIG 10)

What is indicated. Wasting among mothers threatens both their health and survival because it increases their susceptibility to life-threatening diseases and their risk of dying, especially during childbirth. Wasted mothers are more likely to give birth to small infants and to be physically weak. The prevalence of adult wasting indicates a 'critical' food insecurity situation in areas where it is $\geq 40\%$ and a 'serious' food insecurity situation in areas where it is 20-39%.

Data collection method. Wasting in non-pregnant women is defined as a body mass index (BMI) below 18.5 kg/m², which is calculated by dividing body weight by the square of height.

Findings. *Rural Bangladesh* - The prevalence of maternal wasting fluctuated seasonally in rural Bangladesh, ranging from 35% in Aug/Sep to 41% in Dec/Jan. *Khulna Division* - The prevalence of maternal wasting was lower than all other divisions except Chittagong Division, but nevertheless indicates 'serious' food insecurity throughout the year.

Child wasting (SEE FIG 11)

What is indicated. Child wasting (low weight for height) results directly from an inadequate intake of food and/or from diseases. It reflects recent or current nutritional status. The prevalence of child wasting indicates a 'critical' problem in areas where it is $\geq 15\%$ and a 'serious' problem in areas where it is 10-14%.

Data collection method. Child wasting is defined as a weight for height z-score < -2 standard deviations (SD) of the median of the reference population (NCHS).

Findings. *Rural Bangladesh* - Between 9-15% of children aged 0-23 mo and 8-14% of children aged 24-59 mo were wasted. The prevalence was highest

in Jun/Jul and lowest in Dec-Mar. *Khulna Division* - The prevalence of child wasting showed a similar pattern to the national rural average, except that there was greater seasonal variation in prevalence in children aged 24-59 mo (7-17%). Child wasting was a 'serious' or 'critical' problem throughout most of the year.

Child stunting (SEE FIG 12)

What is indicated. Stunting (low height for age) results from consumption of a diet of inadequate quality for a prolonged period of time. As stunting takes time to develop, it reflects past nutritional status or chronic undernutrition. A prevalence of $\geq 40\%$ is considered to be 'very high' and a prevalence of 30-39% is considered 'high'.

Data collection method. Child stunting is defined as a height for age z-score < -2 SD of the median of the reference population (NCHS).

Findings. *Rural Bangladesh* - In rural Bangladesh, 40-45% of children aged 0-23 mo and 50-54% of children aged 24-59 mo were stunted. The prevalence was highest in Feb-Mar and lowest in Aug-Sep. *Khulna Division* - The prevalence of child stunting was lower than all other divisions, albeit 'high' or 'very high' throughout the year.

Child underweight (SEE FIG 13)

What is indicated. Underweight (low weight for age) can be the result of wasting and/or stunting. A prevalence of $\geq 30\%$ is considered 'very high'.

Data collection method. Child underweight is defined as weight for age z-score < -2 SD of the median of the reference population (NCHS).

Findings. *Rural Bangladesh* - Between 41-46% of children aged 0-23 mo and 53-61% of children aged 24-59 mo were underweight. The prevalence was highest in Jun/Jul and lowest in Dec/Jan, and was 'very high' in all divisions throughout all the year. *Khulna Division* - The prevalence of child underweight was lower than all other divisions.

CONCLUSIONS

The NSP recorded substantial improvements in child nutritional status in rural Bangladesh during the 1990s², and surveillance in 2001 has shown that these encouraging trends have continued. However, the prevalence of malnutrition in children and mothers is still amongst the highest in the world. Many millions of children and mothers in rural Bangladesh continue to lack sufficient access to food, health care services and a clean environment.

Fig 12. Percentage of stunted children aged 0-23 mo and 24-59 mo (HAZ < -2 SD) in 2001

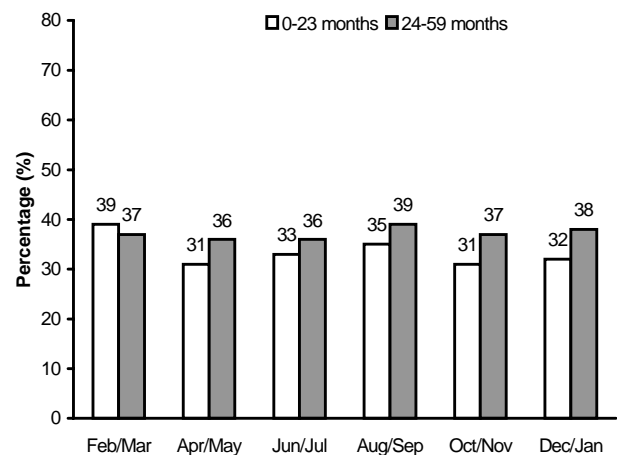
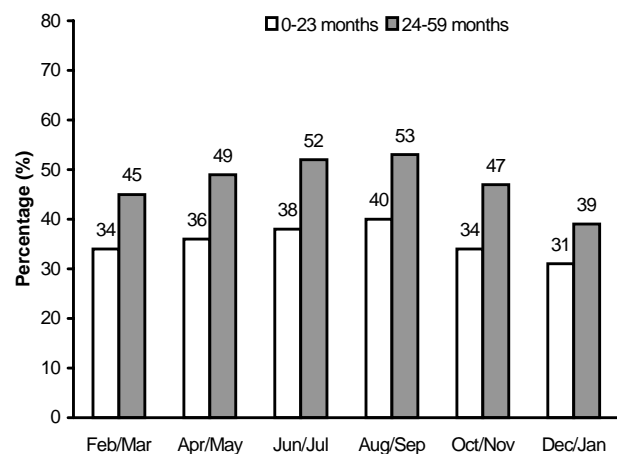


Fig 13. Percentage of underweight children aged 0-23 mo and 24-59 mo (WAZ < -2 SD) in 2001



The findings for Khulna Division in 2001 show that only one-third (33%) of households had an energy intake < 2122 kcal/person/d, even though the percentage of households that took a loan for food was high for the country (25-37%). The prevalence of malnutrition and anemia in children and mother was lower than most other divisions in the country, but was still unacceptably high. According to international criteria, the prevalence of wasting in mothers (32-37%) indicates a 'serious' food insecurity situation throughout the year. Child wasting (7-17% in children aged 0-59 mo) was a 'serious' or 'critical' problem throughout most of the year. The prevalence of child stunting (31-39% in children aged 0-23 mo and 36-39% in children aged 24-59 mo) was 'high' and the prevalence of child underweight (31-40% in children aged 0-23 mo and 39-53% in children aged 24-59 mo) was 'very high'. The low diversity of the diet contradicts the relatively

low prevalence of anemia in this division compared to elsewhere in the country. Anemia was a 'moderate' problem in both children (35%) and mothers (20%). It is possible that the indicator of dietary diversity did not have accurately reflect the quality of the diet in this division, or that other factors may have offset the lack of dietary diversity. For example, the percentage of children breastfed in their second year of life and the percentage of households with a closed latrine was higher than elsewhere in the country, and the percentage of children and mothers with diarrhea was lower than the national rural average. Breastmilk is an important source of dietary iron for children, while diarrhea can be associated with blood loss and anorexia.

All necessary resources should be mobilized at all levels to ensure that faster progress is made in reducing malnutrition in Bangladesh in the coming decade. Direct nutrition interventions are needed to assist those affected by malnutrition, including nutritional rehabilitation and direct feeding programs for the severely malnourished; micronutrient

supplementation to prevent and control anemia and vitamin A deficiency among those at highest risk, particularly young children and women of child-bearing age; and food fortification to improve the micronutrient status of the population as a whole. All food, agriculture and development policies and programs should place greater emphasis on interventions to improve household food security, including crop diversification, homestead food production, employment and income creation, credit facilities, and food assistance. Infectious diseases such as diarrhea are still a major cause of malnutrition, and so households need a sanitary environment and better access to preventive and curative health services. These interventions should be complemented with poverty alleviation strategies that support labor-intensive economic growth, sound macroeconomic management, good governance and social development, including the empowerment of women, and by global trade policies that stimulate the growth of Bangladesh's economy. Surveillance should be used to monitor the implementation of policies and programs and to assess their impact.

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